Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DR. PETER E. GRAYS

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-14-2132-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
MARCH 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Broadspire Insurance has failed to process reimbursement for surgical procedures performed during [Claimant's] surgical session. They have continued to deny payment for the surgical services rendered due to denial reason that the documentation submitted does not support the service billed. We have sent medical provider appeal for reprocessing of this medical bill with the operative report attached, showing all procedures as documented as being completed during this surgical session."

Amount in Dispute: $7,250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The CPT code billed 49507 (Repair initial inguinal hernia, incarcerated or strangulated) is not documented. The operative report states repair of bilateral inguinal hernias which should be code 49505-50. We are not permitted to change codes in TX. As described in the denial letter sent to the provider if they submitted additional information to support the incarcerated or strangulated hernia's as billed or submitted a correct billing we would re-evaluate this claim."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2013	CPT Code 49507-RT Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	$2,000.00	$0.00
	CPT Code 49507-LT Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	$2,000.00	$0.00
	CPT Code 55520-59-RT Excision of lesion of spermatic cord (separate procedure)	$1,000.00	$0.00
	CPT Code 64774-59-RT Excision of neuroma; cutaneous nerve, surgically identifiable	$1,000.00	$0.00
	CPT Code 15271-59 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	$750.00	$0.00

April 4, 2013	CPT Code 15777-59 Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	$750.00	$0.00
TOTAL		$7,250.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1-Workers compensation state fee schedule adjustment.

Issues

1. Does the documentation support billing CPT code 49507-RT and 49507-LT? Is the requestor entitled to reimbursement?
2. Does the documentation support billing CPT code 55520-RT? Is the requestor entitled to reimbursement?
3. Does the documentation support billing CPT code 64474-RT? Is the requestor entitled to reimbursement?
4. Does the documentation support billing CPT code 15271-59? Is the requestor entitled to reimbursement?
5. Does the documentation support billing CPT code 15777-59? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 49507 is defined as "Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated."

   The requestor appended modifiers "RT-right side" and "LT-left side."

   The Operative Report indicates "Incision was made in the right groin, carrier down to external oblique which was then opened. The ilioinguinal nerve was then excised as well as the cord lipoma. A large direct hernia and indirect hernia were both reduced using a large oval patch…In mirror-image fashion, the left inguinal hernia was repaired."

   The Division finds that the requestor's operative report does not discuss that the hernia was incarcerated or strangulated; therefore, the requestor has not supported billing CPT code 49507-RT or 49507-LT. As a result, reimbursement is not recommended.

2. CPT code 55520-RT-59 is defined as "Excision of lesion of spermatic cord (separate procedure)."

   28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per CCI edits, code 55520 is a component of code 49507; however, a modifier is allowed to differentiate the service. The requestor appended modifier "59-Distinct Procedural Service" to code 55520 to designate that it was a separate service.

Modifier "59" is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

A review of the submitted operative report does not support a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." The Division finds that the requestor has not supported the use of modifier "59."

The National Correct Coding Initiative Manual, Chapter 1, titled General Correct Coding Policies defines "separate procedure" as "If a CPT code descriptor includes the term "separate procedure", the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a 'separate procedure' when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.

A CPT code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach. Modifier 59 or a more specific modifier (e.g., anatomic modifier) may be appended to the 'separate procedure' CPT code to indicate that it qualifies as a separately reportable service."

Code 55520 has the parenthetical statement "separate procedure"; therefore, it is a service that is commonly carrier out as a part of a more extensive procedure, and does not warrant separate identification. Because both procedure codes 49507 and 55520 were performed on the same anatomically related region (groin), code 55520 should not be reported with 49507. As a result, reimbursement is not recommended.

3. CPT code 64774-59 is defined as "Excision of neuroma; cutaneous nerve, surgically identifiable." A review of the operative report does not support billing of code 64474. In addition, the requestor appended modifier "59-Distinct Procedural Service" to code 64774 to designate that it was a separate service. A review of the submitted operative report does not support a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." The Division finds that the requestor has not supported the use of modifier "59." As a result, reimbursement is not recommended.

4. CPT code 15271 is defined as "Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area." A review of the operative report indicates "Onlay patch was placed to the pubic tubercle with 2-0 Vicryl sutures." This service does not meet the definition of code 15271; therefore, the requestor has not supported billing code 15271. In addition, the requestor appended modifier "59-Distinct Procedural Service" to code 15271 to designate that it was a separate service. A review of the submitted operative report does not support a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." The Division finds that the requestor has not supported the use of modifier "59." As a result, reimbursement is not recommended.

5. CPT code 15777 is defined as "Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)." A review of the operative report indicates "Onlay patch was placed to the pubic tubercle with 2-0 Vicryl sutures." This service does not meet the definition of code 15777; therefore, the requestor has not supported billing code 15777. In addition, the requestor appended modifier "59-Distinct Procedural Service" to code 15777 to designate that it was a separate service. A review of the submitted operative report does not support a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive

injuries) not ordinarily encountered or performed on the same day by the same individual." The Division finds that the requestor has not supported the use of modifier "59." As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $ 0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/20/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.